General Assembly **Substitute Bill No. 922**

January Session, 2011 *____SB00922INS__022511___*

AN ACT CONCERNING NOTIFICATION OF THE SERVICES OF THE OFFICE OF THE HEALTHCARE ADVOCATE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (1) of subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) Except as provided in subparagraph (F) of this subdivision with respect to a final notice, each notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, **[**and**]** (iii) a statement that the enrollee may contact the Office of the Healthcare Advocate for assistance with the filing of an appeal, and the Internet web site address, electronic mail address and telephone number of said office, and (iv) the procedure to appeal to the commissioner pursuant to section 38a-478n.

(F) Each notice of a final determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) a statement that all internal appeal mechanisms have been exhausted, **[**and**]** (iii) a copy of the

application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n, and (iv) a statement that the enrollee may contact the Office of the Healthcare Advocate for assistance with the filing of an appeal, and the Internet web site address, electronic mail address and telephone number of said office.

Sec. 2. Subsection (a) of section 38a-478m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) Each managed care organization or health insurer, as defined in section 38a-478n, shall establish and maintain an internal grievance procedure to assure that enrollees, as defined in section 38a-478n, may seek a review of any grievance that may arise from a managed care organization's or health insurer's action or inaction, other than action or inaction based on utilization review, and obtain a timely resolution of any such grievance. Such grievance procedure shall comply with the following requirements:

(1) Enrollees shall be informed of the grievance procedure at the time of initial enrollment and at not less than annual intervals thereafter, which notification may be met by inclusion in an enrollment agreement or update. Each enrollee and the enrollee's provider shall also be informed of the grievance procedure when a decision has been made not to certify an admission, service or extension of stay ordered by the provider.

(2) Notices to enrollees and providers describing the grievance procedure shall explain: (A) The process for filing a grievance with the managed care organization or health insurer, which may be communicated orally, electronically or in writing; (B) that the enrollee, or a person acting on behalf of an enrollee, including the enrollee's health care provider, may make a request for review of a grievance; and (C) the time periods within which the managed care organization or health insurer must resolve the grievance. Such notices shall also

include a statement that the enrollee may contact the Office of the Healthcare Advocate for assistance with the filing of a grievance with respect to a decision made by the managed care organization or health insurer not to certify an admission, service or extension of stay ordered by the provider, and the Internet web site address, electronic mail address and telephone number of said office.

(3) Each managed care organization and health insurer shall notify its enrollee in writing in cases where an appeal to reverse a denial of a claim based on medical necessity is unsuccessful. Each notice of a final denial of a claim based on medical necessity shall include (A) a written statement that all internal appeal mechanisms have been exhausted, and (B) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n.

Sec. 3. Section 38a-483b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

Except as otherwise provided in this title, each insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual health insurance policy in this state, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five days after a request for such determination is received by the insurer, health care center, hospital and medical service corporation or other entity. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial **[**. If the reasons for such denial include that the requested service is not medically necessary or is not a covered benefit under such policy, the entity**]** and shall (1) notify the insured that such insured may contact the Office of the Healthcare Advocate **[**if the insured believes the insured has been given erroneous information**]** for assistance with the filing of an

appeal, and (2) provide to such insured the contact information for said office.

Sec. 4. Section 38a-513a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

Except as otherwise provided in this title, each insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any group health insurance policy in this state, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five days after a request for such determination is received by the insurer, health care center, hospital and medical service corporation or other entity. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial **[**. If the reasons for such denial include that the requested service is not medically necessary or is not a covered benefit under such policy, the entity**]** and shall (1) notify the insured that such insured may contact the Office of the Healthcare Advocate **[**if the insured believes the insured has been given erroneous information**]** for assistance with the filing of an appeal, and (2) provide to such insured the contact information for said office.

Sec. 5. Section 38a-1046 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

Each employer **[**, other than a self-insured employer,**]** that provides health insurance benefits to employees shall obtain from the Healthcare Advocate and post, in a conspicuous location, a notice concerning the services that the Healthcare Advocate provides.

This act shall take effect as follows and shall amend the following sections:

Section 1	*October 1, 2011*	38a-226c(a)(1)
Sec. 2	*October 1, 2011*	38a-478m(a)
Sec. 3	*October 1, 2011*	38a-483b
Sec. 4	*October 1, 2011*	38a-513a
Sec. 5	*October 1, 2011*	38a-1046

INS *Joint Favorable Subst.*